TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PROFESSIONAL EMERGENCY SERVICE

Respondent Name
XL INSURANCE AMERICA, INC.

MFDR Tracking Number
M4-16-3209-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 20, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review the entire narrative report for each date of service enclosed to find the components of documentation required by the 1997 Documentation Guidelines for Evaluation Management Services."

Amount in Dispute: $586.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After review, our bill audit company has recommended additional monies for the disputed charges. . . . a copy of the EOB and payment summaries will be sent for your records."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 2, 2016	Professional Services	$586.17	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. After the filing of the request for medical fee dispute resolution, the insurance carrier submitted supplemental response information supporting additional payment to requestor of $425.75 by check dated July 20, 2016.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P1 – [No explanation of this reason code was found with the submitted materials.]
   - P12 – [No explanation of this reason code was found with the submitted materials.]
   - Z710 – *15 (150) PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
   - B1 – SERVICES NOT DOCUMENTED IN PATIENT'S MEDICAL RECORDS
   - B12 – SERVICES NOT DOCUMENTED IN PATIENT'S MEDICAL RECORDS

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with the above claim adjustment reason codes. The insurance carrier issued additional payments on the disputed services after the filing of a medical fee dispute request and did not maintain these denial reasons after reconsideration. The division finds only the amount of the fees remain in dispute. Accordingly, the remaining fee issues will be reviewed for the disputed services pursuant to applicable division rules and fee guidelines.
2. This dispute regards payment for medical services with reimbursement subject to the division's *Medical Fee Guideline for Professional Services*, at 28 Texas Administrative Code §134.203, which requires that to determine the maximum allowable reimbursement (MAR), system participants shall apply Medicare payment policies with minimal modifications as set forth in the rule. Rule §134.203(c) specifies that:

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the division conversion factor.

   The applicable division conversion factor for calendar year 2016 is $56.82.
3. Reimbursement is calculated as follows:

   - For procedure code 99205, the relative value (RVU) for work of 3.17 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 3.22706. The practice expense (PE) RVU of 2.36 multiplied by the PE GPCI of 1.009 is 2.38124. The malpractice RVU of 0.29 multiplied by the malpractice GPCI of 0.772 is 0.22388. The sum of 5.83218 is multiplied by the division conversion factor of $56.82 for a MAR of $331.38.
   - For procedure code 93000, the work RVU of 0.17 multiplied by the work GPCI of 1.018 is 0.17306. The PE RVU of 0.29 multiplied by the PE GPCI of 1.009 is 0.29261. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.772 is 0.01544. The sum of 0.48111 is multiplied by the division conversion factor of $56.82 for a MAR of $27.34. Per Rule §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $26.14.
   - Procedure code A4556 is bundled. Reimbursement for electrodes is included in the payment for the electrocardiogram. Additional payment is not recommended.
   - Procedure code 85025 represents a pathology/laboratory service with reimbursement determined per Rule §134.203(e). The Medicare Clinical Laboratory Fee is $10.59. 125% of this amount is $13.24.

- For procedure code 81000, the Medicare Clinical Laboratory Fee is $4.32. 125% of this amount is $5.40.
- For procedure code 85025, the Medicare Clinical Laboratory Fee is $10.59. 125% of this amount is $13.24.
- For procedure code 85610, the Medicare Clinical Laboratory Fee is $5.36. 125% of this amount is $6.70.
- For procedure code 85730, the Medicare Clinical Laboratory Fee is $8.18. 125% of this amount is $10.23.
- For procedure code 80053, the Medicare Clinical Laboratory Fee is $14.39. 125% of this amount is $17.99. Per Rule §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $15.00.
- Procedure code 71020 represents a professional service with reimbursement determined per Rule §134.203(c). The work RVU of 0.22 multiplied by the work GPCI of 1.018 is 0.22396. The PE RVU of 0.54 multiplied by the PE GPCI of 1.009 is 0.54486. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.772 is 0.01544. The sum of 0.78426 is multiplied by the division conversion factor of $56.82 for a MAR of $44.56.

4. The total MAR for the services in dispute is $465.89. The submitted documentation supports that the insurance carrier has paid $487.86. No additional payment is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	May 11, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.